

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER PORTER REGIONAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST US HWY 6 VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State licensure hospital complaint.</p> <p>Complaint Number: IN00154687</p> <p>Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 1/29/15</p> <p>Facility Number: 005033</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Porter Regional Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, and 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 02/24/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE